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No. 03-40

In the Supreme Court of the United States

JOHN P. WALTERS, ET AL., PETITIONERS

v.

DR. MARCUS CONANT, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

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TABLE OF AUTHORITIES

Cases:	Page
Alliance to End Repression v. *City of Chicago*, 742 F.2d 1007 (7th Cir. 1984)	2, 3
Central Hudson Gas & Elec. Corp. v. *Public Service Comm'n*, 447 U.S. 557 (1980)	8
Giboney v. *Empire Storage & Ice Co.*, 336 U.S. 490 (1949)	7
McGrath v. *Potash*, 199 F.2d 166 (D.C. Cir. 1952)	6
Ohralik v. *Ohio State Bar Ass'n*, 436 U.S. 447 (1978)	7
Pearson v. *McCaffrey*, 139 F. Supp. 2d 113 (D.D.C. 2001)	6
Pittsburgh Press Co. v. *Human Relations Comm'n*, 413 U.S. 376 (1973)	8
Planned Parenthood v. *Casey*, 505 U.S. 833 (1992)	7
Reno v. *American-Arab Anti-Discrimination Comm.*, 525 U.S. 471 (1999)	2
Reporters Comm. v. *AT&T*, 593 F.2d 1030 (D.C. Cir. 1978), cert. denied, 440 U.S. 949 (1979)	2, 3
Simon & Schuster, Inc. v. *Members of the N.Y. State Crime Victims Bd.*, 502 U.S. 105 (1991)	3
Thompson v. *Western States Med. Ctr.*, 535 U.S. 357 (2002)	7, 8
United States v. *Arvizu*, 534 U.S. 266 (2002)	3
United States v. *Swift & Co.*, 286 U.S. 106 (1932)	6

Constitution and statutes:

U.S. Const.:	
Amend. I	1, 2, 3, 7
Amend. IV	3

Statutes—Continued: Page

Controlled Substances Act, 21 U.S.C. 801 *et seq.*:
21 U.S.C. 812(b)(1)(A)-(C) 2, 6, 8
21 U.S.C. 823(f)(4) 4
21 U.S.C. 823(f)(5) 1, 4, 5, 9

Miscellaneous:

15B C. Wright & A. Miller, *Federal Practice and Procedure* (2d ed. 1992) 6

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Respondents all but concede the unprecedented scope of the injunction sustained by the Ninth Circuit. Respondents admit (Br. in Opp. 10, 17-18) that the injunction bars the DEA from even investigating physicians based solely on their recommendations that patients use marijuana, but they make little effort to defend that remarkable intrusion on the Executive's investigatory authority. Nor do respondents make any effort to reconcile it with District of Columbia and Seventh Circuit decisions holding such intrusions improper. Pet. 27-29; pp. 2-3, *infra*. Respondents likewise cannot seriously dispute that the Ninth Circuit has effectively held unconstitutional and enjoined in this context an important provision of an Act of Congress designed to protect the public health and safety. Although respondents assert that the injunction leaves the Controlled Substances Act (CSA) intact, they do so only by incorrectly construing the registration provisions of the CSA as pertaining solely to criminal conduct, and by reading an important regulatory provision —the standard of "threat[] [to] the public health and safety" of 21 U.S.C. 823(f)(5)—out of the Act.

Even on the merits, respondents all but concede that the decision below misapplies the First Amendment. Notably, respondents agree that States may "punish" a "physician who recommends or advises an unreasonably dangerous

treatment." Br. in Opp. 14 n.2. But respondents do not explain how the *First Amendment*—which by virtue of the Fourteenth Amendment is equally applicable to the States—might permit the States to regulate such recommendations or advice, while barring the federal government from doing likewise, particularly where a registered physician "recommends or advises" treatments involving the use of Schedule I controlled substances that have been determined as a matter of federal law to have "a high potential for abuse," "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use" even "under medical supervision," 21 U.S.C. 812(b)(1)(A)-(C).

1. Unlike the Ninth Circuit in this case, the District of Columbia and Seventh Circuits have concluded that judicial interference with the Executive Branch's traditionally broad authority to investigate (*i.e.*, to gather information) on First Amendment "chill" grounds is improper. Pet. 27-28. Those courts have recognized that the First Amendment does not "insulate" citizens "from the general and subjective inhibitions that naturally arise from the prospect of" good faith "investigation[s]—inhibitions to which all citizens are subject in every field of endeavor." *Reporters Comm.* v. *AT&T*, 593 F.2d 1030, 1053 (D.C. Cir. 1978), cert. denied, 440 U.S. 949 (1979). And they recognize that any decree depriving the government of the ability to investigate merely because the subject comes to its attention through activities that in themselves enjoy First Amendment protection would represent "a remarkable judicial intervention in vital executive functions" that trifles with "public safety." *Alliance to End Repression* v. *City of Chicago*, 742 F.2d 1007, 1014, 1015 (7th Cir. 1984) (en banc). See *Reno* v. *American-Arab Anti-Discrimination Comm.*, 525 U.S. 471, 488 (1999) (discussed at Pet. 28-29). Respondents make no effort to reconcile the Ninth Circuit's decision with those cases. That alone is sufficient reason for granting the petition.

Respondents also abandon the Ninth Circuit's justification for that intrusion—that, because "a doctor's recommendation

does not itself constitute illegal conduct, the portion of the injunction barring investigations solely on that basis does not interfere with the federal government's ability to enforce its laws." Pet. App. 12a. As explained in the petition for a writ of certiorari (at 26), *United States* v. *Arvizu*, 534 U.S. 266 (2002), contradicts that assertion, holding that conduct that is not itself criminal can provide reasonable suspicion of criminal activity (and *a fortiori* a reasonable impetus for an administrative investigation). The Seventh Circuit's decision in *Alliance to End Repression*, 742 F.2d at 1014, rejects that assertion as well, explaining that even First Amendment conduct "that cannot be punished" may warrant—or even require—further investigation.

Respondents do argue (Br. in Opp. 18) that the prospect of investigation may have a chilling effect on physicians. But that underscores the inconsistency between the decision below and *Reporters Committee*'s holding that the First Amendment does not "insulate" citizens "from the general and subjective inhibitions that naturally arise from the prospect of * * * investigation." 593 F.2d at 1053. The argument also defies common sense. Individuals have a First Amendment right to engage in myriad activities, from publishing accounts of their criminal (or non-criminal) conduct, *Simon & Schuster, Inc.* v. *Members of the N.Y. State Crime Victims Bd.*, 502 U.S. 105 (1991), to advocating unlawful acts, *Alliance to End Repression*, 742 F.2d at 1014. But that does not entitle them to an injunction prohibiting the government from investigating on those bases, even though the prospect of investigation might chill such expression to some degree. The same is true here, particularly given that the physician conduct at issue is not pure expression but part of the practice of a profession subject to reasonable regulation.[1]

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[1] Respondents' hyperbolic concerns about possible *means* of investigation, such as the use of informants (Br. in Opp. 18), are misplaced. No such means are at issue here, and the Fourth Amendment, not the First, is the constitutional basis for any limits on investigative techniques, and only to the extent they represent "searches" or "seizures." The injunction re-

2. Respondents also err in characterizing the Ninth Circuit's decision as merely invalidating a "federal policy" that is specific to California and Arizona. Br. in Opp. 13, 14. The injunction upheld by the Ninth Circuit does not strike down a "policy," relief that would have allowed the DEA to promulgate a new policy. It permanently enjoins the DEA from ever "(i) revoking a class-member physician's DEA registration merely because the doctor recommends medical marijuana to a patient based on a sincere medical judgment and (ii) from initiating any investigation solely on that ground." Pet. App. 73a; see *id.* at 5a-6a, 9a, 11a-12a. The Ninth Circuit's decision upholding that injunction, moreover, provides the governing law for nine Western States, including seven of the nine States with laws purporting to legalize possession of marijuana based on physician statements. Pet. 6 n.3, 29.

Respondents' claim that the Ninth Circuit leaves the CSA intact also mischaracterizes the CSA as concerned solely with physicians who "effectively become * * * drug dealer[s]," Br. in Opp. 15, such that its purposes are met if the DEA can "revoke the federal license of a physician upon demonstrating * * * that the physician has violated laws regarding distribution of drugs," *id.* at 16. The text of the CSA belies that assertion. It provides for the revocation of a physician's registration not only if he violates controlled substances laws, 21 U.S.C. 823(f)(4), but also if he engages in "[s]uch *other conduct* which may threaten the public health and safety," 21 U.S.C. 823(f)(5) (emphasis added). Indeed, Congress added Section 823(f)(5) and its "other conduct" standard in 1984 for the specific purpose of permitting the DEA to revoke a physician's registration based on conduct that may threaten public health and safety without proof of criminal misconduct. Pet. 18.[2] By prohibiting revocations

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spondents seek to defend, moreover, bars all investigations, whether or not they use the means respondents identify as objectionable.

[2] Respondents' unsubstantiated assertion (Br. in Opp. 25) that the CSA has long drawn a line between "providing medical information as opposed to criminally participating in distribution" is incorrect. Physi-

absent criminal conduct, the Ninth Circuit has deprived the DEA of precisely the authority that Section 823(f)(5) was designed to grant. *Ibid.*[3]

Respondents' alternative claim (Br. in Opp. 14 & n.2, 28-29) that the DEA is impermissibly regulating the practice of medicine is similarly misplaced. Respondents concede (*id.* at 10) that the Ninth Circuit affirmed the injunction relying on "First Amendment principles," not on the theory that the DEA had exceeded its statutory authority.[4] The DEA,

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cians who recommend Schedule I substances as treatments—such as by telling patients to take LSD for schizophrenia or heroin to combat obesity—have long faced the possible loss of DEA registration for engaging in "conduct which may threaten the public health and safety."

[3] Respondents likewise err in asserting (Br. in Opp. 16) that the case is unimportant because the injunction has not prevented criminal prosecutions. First, the DEA is charged with civil responsibilities as well, including protecting public health and safety through physician registration and de-registration. Even with respect to criminal investigations, moreover, respondents would put the government to an impossible burden. Nowhere do respondents explain how the government could develop "evidence" or "a record" of the prosecutions (and administrative proceedings) it has foregone (*ibid.*) when the government is enjoined from conducting any sort of investigation to determine whether there is criminal conduct. In any event, the intrusion on the DEA's enforcement authority is improper without regard to the injury's present magnitude. And, notwithstanding the government's adherence to the injunction, physicians who lose their DEA registration for trafficking in marijuana now challenge the revocation by arguing that the investigation violated the injunction. See, *e.g.*, *DEA* v. *Fry*, No. 03-70379 (9th Cir. to be argued Oct. 7, 2003).

[4] That is of particular significance given that Congress can, by statutory amendment, correct a decision misinterpreting the DEA's statutory authority, but cannot correct an erroneous constitutional holding. Respondents thus err in relying (Br. in Opp. 27-29) on statutory arguments not addressed by the court of appeals. In any event, respondents err in relying on statements in the legislative history of the 1984 amendments concerning Congress's desire to prevent physicians from diverting prescription drugs from medical uses to illegal, non-medical uses. It follows *a fortiori* from those statements that the 1984 amendments allow the DEA to revoke the registration of a physician who makes a recommendation that is the functional equivalent of a prescription under state law for a drug that has no lawful medical use under (and that would be obtained in violation of) federal law. Such conduct is manifestly contrary to the CSA's

moreover, is not regulating the practice of medicine generally, but rather is fulfilling its statutory mandate concerning the registration of physicians to dispense controlled substances consistent with the CSA's public health and safety standard. In doing so, the DEA unquestionably may consider whether a physician prescribes or recommends putative medical "treatments" in which patients are likely to purchase illegal Schedule I substances—like heroin, LSD, or marijuana—on the street, outside of the closed system of distribution established by the CSA, in the absence of any controls regarding potency, content, and quality. Whether the physician advises patients to circumvent the CSA's closed distribution system is surely relevant to the propriety of the physician's registration *under* the CSA. Even the district court in this case (Pet. App. 64a), like the court in *Pearson* v. *McCaffrey*, 139 F. Supp. 2d 113, 121 (D.D.C. 2001), recognized that such activities may constitute "other conduct" that "may threaten the public health and safety." That is particularly true when the conduct concerns Schedule I substances, which have "a high potential for abuse," have "no currently accepted medical use in treatment in the United States," and lack "accepted safety for use" even "under medical supervision," 21 U.S.C. 812(b)(1)(A)-(C).[5]

3. a. Respondents dedicate most of their arguments (Br. in Opp. 19-29) to defending the Ninth Circuit's First Amend-

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closed system of distribution of controlled substances, just as a physician's abuse of ordinary prescription authority would be.

[5] The suggestion that the government should forgo further review and seek to "modify the injunction," Br. in Opp. 16, is likewise without merit. Where, as here, the government objects to the injunction's propriety in the first instance, appellate review rather than a motion to modify is appropriate. 15B C. Wright & A. Miller, *Federal Practice and Procedure* § 3916, at 364-366 (2d ed. 1992). As this Court stated when reviewing the denial of a motion to modify an injunction: "The injunction, whether right or wrong, is not subject to impeachment in its application to the conditions that existed at its making. We are not at liberty to reverse under the guise of readjusting." *United States* v. *Swift & Co.*, 286 U.S. 106, 119 (1932); see *McGrath* v. *Potash*, 199 F.2d 166, 167 (D.C. Cir. 1952).

ment analysis. Their arguments, however, proceed from the assumption that physicians who recommend particular treatments in the course of a physician-patient relationship are not "treating" patients, but rather are engaging in speech by providing "honest information and advice." See, *e.g.*, *id.* at 17. Contrary to that assumption, the provision of medical advice—whether it be that the patient take aspirin or vitamin C, lose or gain weight, exercise or rest, or smoke or refrain from smoking marijuana—is not pure speech; it is the conduct of the practice of medicine. As such, it is subject to reasonable regulation, Pet. 18-20, as cases cited by respondents (Br. in Opp. 20-21) also acknowledge. See, *e.g.*, *Planned Parenthood* v. *Casey*, 505 U.S. 833, 884 (1992) (plurality opinion) (physician's asserted First Amendment right not to speak in discussions with patient is implicated "only as part of the practice of medicine," which is "subject to reasonable licensing and regulation by the State"). It is not an abridgment of free speech to make a course of conduct sanctionable merely because it was initiated or carried out by means of language, whether spoken, written or printed. Pet. 20 (citing *Giboney* v. *Empire Storage & Ice Co.*, 336 U.S. 490, 502 (1949), and *Ohralik* v. *Ohio State Bar Ass'n*, 436 U.S. 447, 456 (1978)).

For that reason, respondents concede that a "physician who recommends or advises an unreasonably dangerous treatment" involving controlled substances "can be punished" by a State because such "[a]dvice and recommendations fall within the state's power." Br. in Opp. 14 n.2. But respondents do not explain how the First Amendment might permit the States to regulate such recommendations or advice, while barring the federal government from doing likewise.

Respondents also ignore (Br. in Opp. 21) the fact that the medical recommendations at issue here, unlike the commercial speech this Court found protected in *Thompson* v. *Western States Medical Center*, 535 U.S. 357 (2002), concern (and if followed will likely lead to) *illegal* conduct. For speech to be protected under the commercial speech doctrine

as applied in *Western States* and *Central Hudson Gas & Electric Corp.* v. *Public Service Commission*, 447 U.S. 557, 566 (1980), the speech must concern *lawful* activity; marijuana use is not lawful activity. See also *Pittsburgh Press Co.* v. *Human Relations Comm'n*, 413 U.S. 376, 388 (1973) ("We have no doubt that a newspaper constitutionally could be forbidden to publish a want ad proposing a sale of narcotics or soliciting prostitutes."). The concern thus is not that physician-provided information may lead to "bad decisions," Br. in Opp. 21, but that physicians registered under the CSA not recommend *illegal* ones, particularly treatments that involve the purchase of drugs, outside the closed system of distribution established by the CSA, with a "high potential for abuse," "no currently accepted medical use in treatment in the United States," and "a lack of accepted safety for use" even "under medical supervision," 21 U.S.C. 812(b)(1)(A)-(C). Respondents therefore are quite wrong in equating (Br. in Opp. 2) physicians' recommendations that their patients smoke marijuana with physicians' recommendations of red wine, acupuncture, and chicken soup—all of which are lawful.

b. For similar reasons, respondents' claim of vagueness is unfounded. Just as physicians are fully capable of determining the recommended "treatments" that might subject them to loss of their medical licenses (or malpractice actions) under state law, they are capable of discerning the "treatments" involving controlled substances that might result in the loss of their registration under the CSA. Indeed, had the DEA not issued the Administration's Response and the Medical Leader Letter to advise physicians that recommending marijuana use to patients as a medical treatment could lead to revocation of their DEA registration, respondents could not have brought this lawsuit. The provision of the additional guidance in the Administration's Response and Medical Leader Letter, however, cannot render the *statutory* criteria that govern any registration determination—

whether the conduct may threaten public health and safety, 21 U.S.C. 823(f)(5)—impermissibly vague.

Respondents' claim that the line between "recommendations" and mere "discussions" "is so vague as to be unintelligible" (Br. in Opp. 22) is also steeped in irony, since it is the *California law* they purportedly seek to effectuate—not the CSA—that uses the term "recommendation." That word has no particular significance under the CSA. The statutory standard of public health and safety under the CSA, as supplemented by the Administration Response and the Medical Leader Letter, in any event offer more than sufficient guidance. Physicians of ordinary intelligence and professional training can understand the difference between a mere discussion of risks and benefits and a recommendation that the patient use a particular option. Physicians who remain concerned can avoid any reasonable possibility of administrative proceedings by exercising due care, such as by offering additional (truthful) information to describe marijuana's status under federal law and to clarify that the physician cannot and is not recommending the use of marijuana—an illegal substance—in contravention of his duty, as a physician registered under the CSA, not to flout the CSA. In any event, physicians have no difficulty understanding that they may be engaging in "conduct which may threaten the public health and safety" within the meaning of 21 U.S.C. 823(f)(5) by recommending Schedule I substances like LSD and heroin as putative medical treatments. Respondents nowhere explain why vagueness concerns suddenly arise simply because the Schedule I substance is marijuana.[6] Nor do re-

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[6] Respondents' reliance (Br. in Opp. 22-23) on the deposition testimony of various officials—not relied upon by the court of appeals—is both misplaced and misleading. It is misplaced because even a public statement by an official cannot render an otherwise valid statutory standard unconstitutionally vague. Otherwise, the constitutionality of any number of federal statutes would rest upon the oratorical ability of whoever is talking about them on any given day. In any event, Director McCaffrey did not state at his deposition that he is "still puzzling" over the *meaning* of the word "recommendation"; he stated that he is "still puzzling over what *to do*

spondents explain why the guidance at issue here is any less precise than the negligence standard applicable to medical advice in malpractice actions.

Finally, respondents' claim of viewpoint discrimination (Br. in Opp. 26-27) is unfounded. The federal government has no interest in whether physicians favor or oppose marijuana use. Physicians are free to express their views publicly, even if that might "promote illegal drug use." *Id.* at 27. But a physician's conduct of the practice of medicine, in the context of a physician-patient relationship, is subject to reasonable governmental regulation, as respondents elsewhere concede. Whether a physician treats patients by recommending marijuana as a medical treatment—while disregarding the substantial likelihood that patients will follow the recommendation by obtaining that substance illegally and in violation of the closed system of distribution established by the CSA—is certainly relevant to the propriety of the physician's registration under the CSA.

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For the reasons given above and in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted.

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about a recommendation," C.A. S.E.R. 441-442 (emphasis added), an unsurprising admission given this litigation. The statement that Director McCaffrey was "not sure what any of it means," Br. in Opp. 22-23, referred not to the Administration's Response, but to the complex hypothetical posed by respondents' counsel. See C.A. S.E.R. 444. Finally, respondents correctly quote Director McCaffrey's statement that he was "not sure *in isolation* * * * what a recommendation is," Br. in Opp. 23 (emphasis added), but they omit the words that immediately follow, "[u]nless it fulfilled precisely what was articulated in the policy statement we put out." C.A. S.E.R. 451.